

EXHIBIT B

APPENDIX A

2006 FEHB BROCHURE

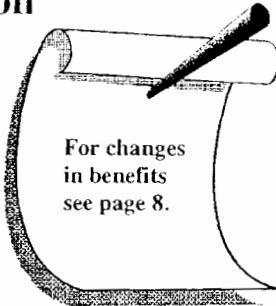


Blue Cross® and Blue Shield® Service Benefit Plan

<http://www.fepblue.org>

2006

**A fee-for-service plan
with a preferred provider organization**



Sponsored and administered by: The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHB

Enrollment codes for this Plan:

- 104 Standard Option - Self Only**
- 105 Standard Option - Self and Family**
- 111 Basic Option - Self Only**
- 112 Basic Option - Self and Family**



**ACCREDITED
HEALTH WEB SITE**



**ACCREDITED
CASE MANAGEMENT**

This Plan has Health Web Site and Case Management accreditation from URAC (also known as the American Accreditation HealthCare Commission). See the 2006 FEHB Guide for more information on accreditation.

Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 71-005

Notice of the United States Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the Government Accountability Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
 United States Office of Personnel Management
 P.O. Box 707
 Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

Important Notice from the Blue Cross and Blue Shield Service Benefit Plan About Our Prescription Drug Coverage and Medicare

OPM has determined that the Blue Cross and Blue Shield Service Benefit Plan's prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and the Blue Cross and Blue Shield Service Benefit Plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan** under our contract (CS 1039) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan on behalf of the Blue Cross and Blue Shield Association (the Carrier). The address for the Blue Cross and Blue Shield Service Benefit Plan administrative office is:

Blue Cross and Blue Shield Service Benefit Plan

1310 G Street, NW, Suite 900
Washington, DC 20005

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health care benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 8. Rates are shown on the back cover of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means the Blue Cross and Blue Shield Service Benefit Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor or other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 1-800-FEP-8440 (1-800-337-8440) and explain the situation.

If we do not resolve the issue:

CALL — THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:

Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

Your child over age 22 (unless he/she is disabled and incapable of self support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Do not assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery?
 - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.html. The Agency for Healthcare Research and Quality makes available a wide-ranging set of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this fee-for-service Plan

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

General features of our Standard and Basic Options

We also have a Preferred Provider Organization (PPO)

Our fee-for-service plan offers services through a PPO. When you use our PPO (Preferred) providers, you will receive covered services at a reduced cost. Your Local Plan (or, for retail pharmacies, Caremark) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO (Preferred) providers and to verify their continued participation. You can also go to our Web page, www.fepblue.org, which you can reach through the FEHB Web site, www.opm.gov/insure. Contact your Local Plan to request a PPO directory.

Under Standard Option, PPO (Preferred) benefits apply only when you use a PPO (Preferred) provider. PPO networks may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas. If no PPO (Preferred) provider is available, or you do not use a PPO (Preferred) provider, non-PPO (Non-preferred) benefits apply.

Under Basic Option, you must use Preferred providers in order to receive benefits. See page 11 for the exceptions to this requirement.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

How we pay professional and facility providers

We pay benefits when we receive a claim for covered services. Each Local Plan contracts with hospitals and other health care facilities, physicians, and other health care professionals in its service area, and is responsible for processing and paying claims for services you receive within that area. Many, but not all, of these contracted providers are in our PPO (Preferred) network.

- **PPO providers.** PPO (Preferred) providers have agreed to accept a specific negotiated amount as payment in full for covered services provided to you. **We refer to PPO facility and professional providers as “Preferred.”** They will generally bill the Local Plan directly, who will then pay them directly. You do not file a claim. Your out-of-pocket costs are generally less when you receive covered services from Preferred providers, and are limited to your coinsurance or copayments (and, under **Standard Option** only, the applicable deductible).
- **Participating providers.** Some Local Plans also contract with other providers that are not in our Preferred network. **If they are professionals, we refer to them as “Participating” providers. If they are facilities, we refer to them as “Member” facilities.** They have agreed to accept a different negotiated amount than our Preferred providers as payment in full. They will also generally file your claims for you. They have agreed not to bill you for more than your applicable deductible, and coinsurance or copayments, for covered services. We pay them directly, but at our Non-preferred benefit levels. Your out-of-pocket costs will be greater than if you use Preferred providers.

Note: Not all areas have Participating providers and/or Member facilities. To verify the status of a provider, please contact the Local Plan where the services will be performed.

- **Non-participating providers.** Providers who are not Preferred or Participating providers do not have contracts with us, or may not accept our allowance. **We refer to them as “Non-participating providers” generally, although if they are not preferred providers, we refer to them as “Non-member facilities.”** When you use Non-participating providers, you may have to file your claims with us. We will then pay our benefits to you, and you must pay the provider.

You must pay any difference between the amount Non-participating providers charge and our allowance (except in certain circumstances – see page 114). In addition, you must pay any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Under Standard Option, your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use Preferred or Participating providers.** Under Basic Option, you must use Preferred providers to receive benefits. See page 11 for the exceptions to this requirement.

Note: In Local Plan areas, Preferred providers and Participating providers who contract with us will accept 100% of the Plan allowance as payment in full for covered services. As a result, you are only responsible for applicable coinsurance or copayments (and, under **Standard Option** only, the applicable deductible), for covered services, and any charges for noncovered services.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and providers. OPM’s FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Care management, including medical practice guidelines;
- Disease management programs; and
- How we determine if procedures are experimental or investigational.

If you want more information about us, call or write to us. Our telephone number and address are shown on the back of your Service Benefit Plan ID card. You may also visit our Web site at www.fepblue.org.

Section 2. How we change for 2006

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 (Benefits). Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- On page 10, under **Covered providers**, Arizona and West Virginia are designated as medically underserved areas in 2006. Texas is no longer designated as a medically underserved area in 2006.

Changes to this Plan

Changes to our Standard Option only

- Your share of the non-Postal premium will increase by 14.5% for Self Only or 14.8% for Self and Family.
- We now provide limited benefits for services provided by licensed chiropractors. (See page 43.)
- We now provide limited benefits for services provided by licensed acupuncturists. (See page 43.)

Changes to our Basic Option only

- Your share of the non-Postal premium will not change for Self Only or for Self and Family.
- We now provide benefits in full for diagnostic tests billed by the outpatient department of a hospital or ambulatory surgical center. Previously, these services were subject to a \$40 copayment. (See pages 62 and 63.)
- Your responsibility for covered inpatient maternity care billed by a Preferred facility (including Preferred birthing facilities) is limited to \$100 per admission. Previously, members paid a copayment of \$100 per day, up to \$500 for the admission. (See page 32.)
- Your copayment for formulary brand-name drugs is increased from \$25 to \$30 for up to a 34-day supply. (See page 83.)

Changes to both our Standard and Basic Options

- We now provide Preventive care benefits for colonoscopies when performed for cancer screening. (See page 30.)
- We now provide Preventive care benefits for ultrasound screenings for aortic abdominal aneurysms. (See page 30.)
- We now provide Preventive care benefits for children who receive meningococcal vaccines. (See page 31.)
- We now provide benefits for outpatient cognitive rehabilitation therapy when performed by a licensed therapist or physician. (See page 37.)
- We now provide benefits for penile prosthesis to treat erectile dysfunction resulting from prostatectomy to treat prostate cancer. (See pages 40, 48, and 98.)
- We now provide benefits for up to 4 visits per year for outpatient nutritional counseling when billed by a covered provider. This visit limitation does not apply to outpatient nutritional counseling provided for the treatment of anorexia or bulimia. (See page 44.)
- We expanded our coverage for organ/tissue transplants to include coverage for additional diagnoses. In addition, we clarified the benefits provided for transplant support services. (See the section beginning on page 50.)
- We now provide benefits for pulmonary rehabilitation performed and billed by the outpatient department of a hospital or freestanding ambulatory facility. (See page 62.)
- We changed the way we calculate our allowance for covered services you receive from Non-participating professionals. For Non-participating professional care, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2) the 2006 Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Previously, we used 80% of the UCR amount in our benefit calculation. (See page 113.)
- We changed our allowance for certain covered services you receive at Non-member facilities. For most types of inpatient stays at Non-member facilities, our allowance is based on a per diem amount for your type of admission developed from the average amount paid for our members nationally to contracting and non-contracting facilities. For inpatient stays resulting from medical emergencies or accidental injuries, or for routine deliveries, our allowance is the billed amount. For outpatient, non-emergency surgical services provided by Non-member facilities, our allowance is the average amount for outpatient surgical services that we pay nationally to contracting and non-contracting facilities. For other outpatient services provided by Non-member facilities, and for outpatient surgical services resulting from a medical emergency or accidental injury, our allowance is the billed amount (minus any amounts for noncovered services). (See pages 59 and 113.)
- Benefits for dental accidental injury care are no longer limited to care completed within 12 months of the accident. (See page 89.)

Section 3. How you receive benefits

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You will need it whenever you receive services from a covered provider, or fill a prescription through a Preferred retail or internet pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call the Local Plan serving the area where you reside and ask them to assist you, or write to us directly at: FEP Enrollment Services, 840 First Street, NE, Washington, DC 20065. You may also request replacement cards through our Web site, www.fepblue.org.

Where you get covered care

Under Standard Option, you can get care from any “covered professional provider” or “covered facility provider.” How much we pay – and you pay – depends on the type of covered provider you use. If you use our Preferred, Participating, or Member providers, you will pay less.

Under Basic Option, you **must** use those “covered professional providers” or “covered facility providers” that are **Preferred providers** for Basic Option in order to receive benefits. Please refer to page 11 for the exceptions to this requirement. Refer to page 6 for more information about Preferred providers.

For Basic Option, the term “primary care provider” includes family practitioners, general practitioners, medical internists, pediatricians, obstetricians/gynecologists, and physician assistants.

• Covered professional providers

We consider the following to be covered professionals when they perform services within the scope of their license or certification:

Physicians – Doctors of medicine (M.D.); osteopathy (D.O.); dental surgery (D.D.S.); medical dentistry (D.M.D.); podiatric medicine (D.P.M.); optometry (O.D.); and chiropractic (D.C.).

Other Covered Health Care Professionals – Professionals who provide additional covered services and meet the state’s applicable licensing or certification requirements and the requirements of the Local Plan. Examples of other covered health care professionals include:

- **Audiologist** – A professional who, if the state requires it, is licensed, certified, or registered as an audiologist where the services are performed.
- **Clinical Psychologist** – A psychologist who (1) is licensed or certified in the state where the services are performed; (2) has a doctoral degree in psychology (or an allied degree if, in the individual state, the academic licensing/certification requirement for clinical psychologist is met by an allied degree) or is approved by the Local Plan; and (3) has met the clinical psychological experience requirements of the individual State Licensing Board.
- **Clinical Social Worker** – A social worker who (1) has a master’s or doctoral degree in social work; (2) has at least two years of clinical social work practice; and (3) if the state requires it, is licensed, certified, or registered as a social worker where the services are performed.
- **Diabetic Educator** – A professional who, if the state requires it, is licensed, certified, or registered as a diabetic educator where the services are performed.
- **Dietician** – A professional who, if the state requires it, is licensed, certified, or registered as a dietician where the services are performed.
- **Independent Laboratory** – A laboratory that is licensed under state law or, where no licensing requirement exists, that is approved by the Local Plan.
- **Nurse Midwife** – A person who is certified by the American College of Nurse Midwives or, if the state requires it, is licensed or certified as a nurse midwife.
- **Nurse Practitioner/Clinical Specialist** – A person who (1) has an active R.N. license in the United States; (2) has a baccalaureate or higher degree in nursing; and (3) if the state requires it, is licensed or certified as a nurse practitioner or clinical nurse specialist.

- **Nursing School Administered Clinic** – A clinic that (1) is licensed or certified in the state where services are performed; and (2) provides ambulatory care in an outpatient setting – primarily in rural or inner-city areas where there is a shortage of physicians. Services billed by these clinics are considered outpatient “office” services rather than facility charges.
- **Nutritionist** – A professional who, if the state requires it, is licensed, certified, or registered as a nutritionist where the services are performed.
- **Physical, Speech, and Occupational Therapist** – A professional who is licensed where the services are performed or meets the requirements of the Local Plan to provide physical, speech, or occupational therapy services.
- **Physician Assistant** – A person who is nationally certified by the National Commission on Certification of Physician Assistants in conjunction with the National Board of Medical Examiners or, if the state requires it, is licensed, certified, or registered as a physician assistant where the services are performed.
- **Other professional providers** specifically shown in the benefit descriptions in Section 5.

Medically underserved areas. In states that OPM determines are “medically underserved”:

Under Standard Option, we cover any licensed medical practitioner for any covered service performed within the scope of that license.

Under Basic Option, we cover any licensed medical practitioner who is **Preferred** for any covered service performed within the scope of that license.

For 2006, the states are: Alabama, Alaska, Arizona, Idaho, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, West Virginia, and Wyoming.

• **Covered facility providers**

Covered facilities include those listed below, when they meet the state's applicable licensing or certification requirements.

- **Hospital** – An institution, or a distinct portion of an institution, that:
 - (1) Primarily provides diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of injured and sick persons provided or supervised by a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.), for compensation from its patients, on an inpatient or outpatient basis;
 - (2) Continuously provides 24-hour-a-day professional registered nursing (R.N.) services; and
 - (3) Is not, other than incidentally, an extended care facility; a nursing home; a place for rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or a custodial or domiciliary institution having as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

Note: We consider college infirmaries to be Non-member hospitals. In addition, we may, at our discretion, recognize any institution located outside the 50 states and the District of Columbia as a Non-member hospital.

- **Freestanding Ambulatory Facility** – A freestanding facility, such as an ambulatory surgical center, freestanding surgi-center, freestanding dialysis center, or freestanding ambulatory medical facility, that:
 - (1) Provides services in an outpatient setting;
 - (2) Contains permanent amenities and equipment primarily for the purpose of performing medical, surgical, and/or renal dialysis procedures;
 - (3) Provides treatment performed or supervised by doctors and/or nurses, and may include other professional services performed at the facility; and
 - (4) Is not, other than incidentally, an office or clinic for the private practice of a doctor or other professional.

Note: We may, at our discretion, recognize any other similar facilities, such as birthing centers, as freestanding ambulatory facilities.

- **Blue Quality Centers for Transplant (BQCT)**

In addition to Preferred transplant facilities, you have access to the Blue Quality Centers for Transplant (BQCT), a centers of excellence program. BQCT institutions are selected based on their ability to meet defined clinical quality criteria that are unique for each type of transplant. BQCT negotiates a payment for transplant services performed during the transplant period (see page 114 for the definition of "transplant period").

Members who choose to use a BQCT facility for a covered transplant only pay the \$100 per admission copayment under Standard Option, or the \$100 per day copayment (\$500 maximum) under Basic Option, for the transplant period. Members are not responsible for additional costs for included professional services. Regular Preferred benefits (subject to the regular cost-sharing levels for facility and professional services) are paid for pre- and post-transplant services performed in BQCT facilities before and after the transplant period.

BQCT institutions are available for seven types of transplants: heart; heart-lung; single or double lung; liver; pancreas; simultaneous pancreas-kidney; and autologous or allogeneic bone marrow (see page 56 for limitations).

All members (including those who have Medicare Part A or another group health insurance policy as their primary payer) must contact us at the customer service number listed on the back of their ID card before obtaining services. We will refer you to the designated Plan transplant coordinator for information about BQCT and approved facilities, and assistance in arranging for your transplant at a BQCT facility.

- **Cancer Research Facility** – A facility that is:

- (1) A National Cooperative Cancer Study Group institution that is funded by the National Cancer Institute (NCI) and has been approved by a Cooperative Group as a blood or marrow stem cell transplant center;
- (2) An NCI-designated Cancer Center; or
- (3) An institution that has a peer-reviewed grant funded by the National Cancer Institute (NCI) or National Institutes of Health (NIH) to study allogeneic or autologous blood or marrow stem cell transplants.

- **Other facilities** specifically listed in the benefits descriptions in Section 5(c).

What you must do to get covered care

Under Standard Option, you can go to any covered provider you want, but in some circumstances, we must approve your care in advance.

Under Basic Option, you **must** use **Preferred** providers in order to receive benefits, except under the special situations listed below. In addition, we must approve certain types of care in advance. Please refer to Section 4, *Your costs for covered services*, for related benefits information.

- (1) Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport as described in Section 5(d), *Emergency services/accidents*;
- (2) Professional care provided at Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons;
- (3) Laboratory and pathology services. X-rays, and diagnostic tests billed by Non-preferred laboratories, radiologists, and outpatient facilities;
- (4) Services of assistant surgeons;
- (5) Special provider access situations (contact your Local Plan for more information); or
- (6) Care received outside the United States and Puerto Rico.

Unless otherwise noted in Section 5, when services of Non-preferred providers are covered in a special exception, benefits will be provided based on the Plan allowance. You are responsible for the applicable coinsurance or copayment, and may also be responsible for any difference between our allowance and the billed amount.

- **Transitional care**

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or
- lose access to your Preferred specialist because we terminate our contract with your specialist for other than cause,

you may be able to continue seeing your specialist and receiving any Preferred benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and any Preferred benefits will continue until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call us immediately. If you have not yet received your Service Benefit Plan ID card, you can contact your Local Plan at the telephone number listed in your local telephone directory. If you already have your new Service Benefit Plan ID card, call us at the number on the back of the card. If you are new to the FEHB Program, we will reimburse you for your covered expenses while in the hospital.

However, if you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for . . .

- **Your hospital stay**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay, the procedure(s)/service(s) to be performed, and the number of days required to treat your condition. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your care, you should always ask your physician or hospital whether they have contacted us.

Warning:

We will reduce our benefits for the inpatient hospital stay by \$500 if no one contacts us for precertification. If the stay is not medically necessary, we will not pay any benefits.

How to precertify an admission

- You, your representative, your doctor, or your hospital must call us at the telephone number listed on the back of your Service Benefit Plan ID card any time prior to admission.
- If you have an **emergency admission** due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, your doctor, or your hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
 - Enrollee's name and Plan identification number;
 - Patient's name, birth date, and phone number;
 - Reason for hospitalization, proposed treatment, or surgery;

- Name and phone number of admitting doctor;
- Name of hospital or facility; and
- Number of planned days of confinement.

• We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

Maternity care

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

If your hospital stay needs to be extended:

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your doctor, or the hospital must ask us to approve the additional days.

What happens when you do not follow the precertification rules

If no one contacted us, we will decide whether the hospital stay was medically necessary.

- If we determine that the stay was medically necessary, we will pay the inpatient charges, less the \$500 penalty. [See Section 5(c) for payment information.]
- If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

If we denied the precertification request, we will not pay inpatient hospital benefits or inpatient physician care benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

When we precertified the admission but you remained in the hospital beyond the number of days we approved and you did not get the additional days precertified, then:

- for the part of the admission that was medically necessary, we will pay inpatient benefits, but
- for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and we will not pay inpatient benefits.

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payer for the hospital stay. (See page 11 for special instructions regarding admissions to BQCT institutions.)
- Your Medicare Part A is the primary payer for the hospital stay. (See page 11 for special instructions regarding admissions to BQCT institutions.)

Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then you **do** need precertification.

• Other services**These services require prior approval under both Standard and Basic Option:**

- **Home hospice care** – Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination and advise you which home hospice care agencies we have approved.
- **Partial hospitalization or intensive outpatient treatment for mental health/substance abuse** – Contact us at the mental health and substance abuse number listed on the back of your ID card before obtaining services for intensive outpatient treatment or partial hospitalization from Preferred providers. We will request the medical evidence we need to make our coverage determination. We will also consider the necessary duration of either of these services.

- **Organ/tissue transplants** – Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. We will consider whether the facility is approved for the procedure and whether you meet the facility's criteria.
- **Clinical trials for certain organ/tissue transplants** – See pages 53 and 54 for the list of conditions covered **only** in clinical trials for blood or marrow stem cell transplants. Contact our Transplant Clinical Trials Information Unit at 1-800-225-2268 for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination.

Note: For the purposes of the blood or marrow stem cell clinical trial transplants listed on pages 53 and 54, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board of the Cancer Research Facility (see page 11) where the procedure is to be delivered.

- **Prescription drugs** – Certain prescription drugs require prior approval. Contact our Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077 for the hearing impaired) to request prior approval, or to obtain an updated list of prescription drugs that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See page 86 for more about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

Note: Benefits for drugs to aid smoking cessation that require a prescription by Federal law are limited to one course of treatment per calendar year. Prior approval is required before benefits will be provided for additional medication. To obtain approval, the physician must certify the patient is participating in a smoking cessation program that provides clinical treatment, including counseling and behavioral therapies.

Note: Until we approve them, you must pay for these drugs in full when you purchase them – even if you purchase them at a Preferred retail pharmacy or through an internet pharmacy – and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you.

Under **Standard Option**, members may use our Mail Service Prescription Drug Program to fill their prescriptions. However, the Mail Service Prescription Drug Program also will not fill your prescription until you have obtained prior approval. Caremark, the administrator of the Mail Service Prescription Drug Program, will hold your prescription for you up to thirty days. If prior approval is not obtained within 30 days, your prescription will be returned to you along with a letter explaining the prior approval procedures.

The Mail Service Prescription Drug Program is not available under **Basic Option**.

In addition to the types of care listed above, these services also require prior approval under Basic Option:

- **Outpatient mental health and substance abuse treatment** – **You must call us** at the number listed on the back of your ID card for mental health and substance abuse **before receiving any outpatient professional or facility care**. We will then provide you with the names and phone numbers of several Preferred providers to choose from and tell you how many visits we are initially approving.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for your covered care:

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: If you have Standard Option when you see your Preferred physician, you pay a copayment of \$15 for the office visit and we then pay the remainder of the amount we allow for the office visit. (You may have to pay separately for other services you receive while in the physician's office.) When you go into a Preferred hospital, you pay a copayment of \$100 per admission. We then pay the remainder of the amount we allow for the covered services you receive.

Copayments do not apply to services and supplies that are subject to a deductible and/or coinsurance amount.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward your deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply that you then pay counts toward meeting your deductible.

Under Standard Option, the calendar year deductible is \$250 per person. Under a family enrollment, the calendar year deductible for each family member is satisfied and benefits are payable for all family members when the combined covered expenses of the family reach \$500.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is \$100, the provider has an agreement with us to accept \$80, and you have not paid any amount toward meeting your Standard Option calendar year deductible, you must pay \$80. We will apply \$80 to your deductible. We will begin paying benefits once the remaining portion of your Standard Option calendar year deductible (\$170) has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Under Basic Option, there is **no calendar year deductible**.

Coinurance

Coinurance is the percentage of the Plan allowance that you must pay for your care. Your coinsurance is based on the Plan allowance, or billed amount, whichever is less. **Under Standard Option only**, coinsurance does not begin until you meet your deductible.

Example: You pay 10% of the Plan allowance under Standard Option for durable medical equipment obtained from a Preferred provider, after meeting your \$250 calendar year deductible.

Note: If your provider routinely waives (does not require you to pay) your applicable deductible (under Standard Option only), coinsurance, or copayments, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

Example: If your physician ordinarily charges \$100 for a service but routinely ~~waives~~ your 25% Standard Option coinsurance, the actual charge is \$75. We will pay \$56.25 (75% of the actual charge of \$75).

Waivers

In some instances, a Preferred, Participating, or Member provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the content of the contracts that the Local Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at the customer service number on the back of your ID card.

Differences between our allowance and the bill

Our "**Plan allowance**" is the amount we use to calculate our payment for certain types of covered services. Fee-for-service plans arrive at their allowances in different ways, so allowances vary. For information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the type of provider you use. In this Plan, we have the following types of providers:

- **Preferred providers.** These types of providers have agreements with the Local Plan to limit what they bill our members. Because of that, when you use a Preferred provider, your share of the provider's bill for covered care is limited.

Under Standard Option, your share consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a Preferred physician who charges \$150, but our allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 10% of our \$100 allowance (\$10). Because of the agreement, your Preferred physician will not bill you for the \$50 difference between our allowance and his/her bill.

Under Basic Option, your share consists only of your copayment or coinsurance amount, since there is no calendar year deductible. Here is an example involving a copayment: You see a Preferred physician who charges \$150 for covered services subject to a \$20 copayment. Even though our allowance may be \$100, you still pay just the \$20 copayment. Because of the agreement, your Preferred physician will not bill you for the \$130 difference between your copayment and his/her bill.

Remember, under Basic Option, you must use Preferred providers in order to receive benefits. See page 11 for the exceptions to this requirement.

- **Participating providers.** These types of **Non-preferred providers** have agreements with the Local Plan to limit what they bill our **Standard Option** members.

Under Standard Option, when you use a Participating provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a Participating physician who charges \$150, but the Plan allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 25% of our \$100 allowance (\$25). Because of the agreement, your Participating physician will not bill you for the \$50 difference between our allowance and his/her bill.

Under Basic Option, there are no benefits for care performed by Participating providers; you pay all charges. See page 11 for the exceptions to this requirement.

- **Non-participating providers.** These **Non-preferred providers** have no agreement to limit what they will bill you.

Under Standard Option, when you use a Non-participating provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and the charges on the bill (except in certain circumstances – see page 114). For example, you see a Non-participating physician who charges \$150. The Plan allowance is again \$100, and you have met your deductible. You are responsible for your coinsurance, so you pay 25% of the \$100 Plan allowance or \$25. Plus, because there is no agreement between the Non-participating physician and us, the physician can bill you for the \$50 difference between our allowance and his/her bill.

Under Basic Option, there are no benefits for care performed by Non-participating providers; you pay all charges. See page 11 for the exceptions to this requirement.

The following table illustrates examples of how much you have to pay out-of-pocket for services from a Preferred physician, a Participating physician, and a Non-participating physician. The table uses our example of a service for which the physician charges \$150 and the Plan allowance is \$100. For Standard Option, the table shows the amount you pay if you have met your calendar year deductible.

EXAMPLE	Preferred physician Standard Option	Preferred physician Basic Option	Participating physician (Standard Option*)	Non-participating physician (Standard Option*)
Physician's charge	\$150	\$150	\$150	\$150
Our allowance	We set it at: 100	We set it at: 100	We set it at: 100	We set it at: 100
We pay	90% of our allowance: 90	Our allowance less copay: 80	75% of our allowance: 75	75% of our allowance: 75
You owe: Coinsurance	10% of our allowance: 10	Not applicable	25% of our allowance: 25	25% of our allowance: 25
You owe: Copayment	Not applicable	20	Not applicable	Not applicable
+Difference up to charge?	No: 0	No: 0	No: 0	Yes: 50
TOTAL YOU PAY	\$10	\$20	\$25	\$75

***Under Basic Option, there are no benefits for care performed by Participating and Non-participating physicians. You must use Preferred providers in order to receive benefits.** See page 11 for the exceptions to this requirement.

Note: Under Standard Option, had you not met any of your deductible in the above examples, only our allowance (\$100), which you would pay in full, would count toward your deductible.

- **Overseas providers.** We pay overseas claims at Preferred benefit levels, using an Overseas Fee Schedule as our Plan allowance. Most overseas professional providers are under no obligation to accept our allowance, and you must pay any difference between our payment and the provider's bill. For facility care you receive overseas, we provide benefits in full after you pay the applicable copayment or coinsurance (and, under Standard Option, any deductible amount that may apply). See Section 5(i) for more information about our overseas benefits.
- **Dental care.** **Under Standard Option**, we pay scheduled amounts for routine dental services and you pay any balance. **Under Basic Option**, you pay \$20 for any covered evaluation and we pay the balance for covered services. See Section 5(h) for a listing of covered dental services and additional payment information.
- **Hospital care.** You pay the coinsurance or copayment amounts listed in Section 5(c). **Under Standard Option**, you must meet your deductible before we begin providing benefits for certain hospital-billed services. **Under Basic Option**, you must use Preferred facilities in order to receive benefits. See page 11 for the exceptions to this requirement.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

If the total amount of out-of-pocket expenses in a calendar year for you and your covered family members for deductibles (Standard Option only), coinsurance, and copayments (other than those listed below) exceeds \$6,000 under Standard Option, or \$5,000 under Basic Option, then you and any covered family members will not have to continue paying them for the remainder of the calendar year.

Standard Option Preferred maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds \$4,000 in a calendar year under Standard Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year when you continue to use Preferred providers. You will, however, have to pay them when you use Non-preferred providers, until your out-of-pocket expenses (for the services of both Preferred and Non-preferred providers) reach \$6,000 under Standard Option, as shown above.

Basic Option maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds \$5,000 in a calendar year under Basic Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year.

The following expenses are not included under this feature. These expenses do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay them even after your expenses exceed the limits described above.

- The difference between the Plan allowance and the billed amount. See pages 16-17;
- Expenses for services, drugs, and supplies in excess of our maximum benefit limitations;
- Under Standard Option, your 30% coinsurance for inpatient care in a Non-member hospital;
- Under Standard Option, your 25% coinsurance for outpatient care by a Non-member facility;
- Your expenses for mental conditions and substance abuse care by a Non-preferred professional or facility provider;
- Your expenses for dental services in excess of our fee schedule payments under Standard Option. See Section 5(h);
- The \$500 penalty for failing to obtain precertification, and any other amounts you pay because we reduce benefits for not complying with our cost containment requirements;
- Under Basic Option, coinsurance you pay for non-formulary brand-name drugs; and
- Under Basic Option, your expenses for care received from Participating/Non-participating professional providers or Member/Non-member facilities, except for coinsurance and copayments you pay in those special situations where we do pay for care provided by Non-preferred providers. Please see page 11 for the exceptions to the requirement to use Preferred providers.

Carryover

Note: If you change to another plan during Open Season, we will continue to provide benefits between January 1 and the effective date of your new plan.

- If you had already paid the out-of-pocket maximum, we will continue to provide benefits as described on this page until the effective date of your new plan.
- If you had not yet paid the out-of-pocket maximum, we will apply any expenses you incur in January (before the effective date of your new plan) to our prior year's out-of-pocket maximum. Once you reach the maximum, you do not need to pay our deductibles, copayments, or coinsurance amounts (except as shown on this page) from that point until the effective date of your new plan.

Note: Because benefit changes are effective January 1, we will apply our next year's benefits to any expenses you incur in January.

Note: If you change options in this Plan during the year, we will credit the amount already accumulated toward the catastrophic protection out-of-pocket limit of your new option to the catastrophic protection out-of-pocket limit of your new option. If you change from Self Only to Self and Family, or vice versa, during the calendar year, please call us about your out-of-pocket accumulations and how they carry over.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

Note: We will generally first seek recovery from the provider if we paid the provider directly, or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment.

When you are age 65 or over and you do not have Medicare

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those benefits you would be entitled to if you had Medicare. And, your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care is not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you...

- are age 65 or over; and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, **or** as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care,

- the law requires us to base our payment on an amount – the “equivalent Medicare amount” – set by Medicare’s rules for what Medicare would pay, not on the actual charge;
- you are responsible for your deductible (Standard Option only), coinsurance, or copayments you owe under this Plan;
- you are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you; and
- the law prohibits a hospital from collecting more than the equivalent Medicare amount.

And, for your physician care, the law requires us to base our payment and your applicable coinsurance or copayment on...

- an amount set by Medicare and called the “Medicare approved amount,” or
- the actual charge if it is lower than the Medicare approved amount.

If your physician...	Then you are responsible for...	
Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network	Standard Option:	your deductibles, coinsurance, and copayments
	Basic Option:	your copayments and coinsurance
Participates with Medicare or accepts Medicare assignment and is not in our Preferred network	Standard Option:	your deductibles, coinsurance, and copayments, and any balance up to the Medicare approved amount
	Basic Option:	all charges
Does not participate with Medicare, and is in our Preferred network	Standard Option:	your deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare approved amount
	Basic Option:	your copayments and coinsurance, and any balance up to 115% of the Medicare approved amount
		Note: In many cases, your payment will be less because of our Preferred agreements. Contact your Local Plan for information about what your specific Preferred provider can collect from you.
Does not participate with Medicare and is not in our Preferred network	Standard Option:	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount
	Basic Option:	all charges

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

**When you have the
Original Medicare Plan
(Part A, Part B, or both)**

We limit our payment to an amount that supplements the benefits that Medicare pays under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays.

Note: We pay our regular benefits for emergency services to a facility provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

- If your physician **accepts** Medicare assignment, then you pay nothing for covered charges (see note below for Basic Option).
- If your physician **does not accept** Medicare assignment, then you pay the difference between the “limiting charge” or the physician’s charge (whichever is less) and our payment combined with Medicare’s payment (see note below for Basic Option).

Note: Under **Basic Option**, you must see **Preferred** providers in order to receive benefits. See page 11 for the exceptions to this requirement.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the “limiting charge.” The Medicare Summary Notice (MSN) form that you receive from Medicare will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

Please see Section 9, *Coordinating benefits with other coverage*, for more information about how we coordinate benefits with Medicare.

Section 5. Standard and Basic Option Benefits

See page 8 for how our benefits changed this year. Page 123 and page 124 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Standard and Basic Option Overview

This Plan offers both a Standard and Basic Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Standard and Basic Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the *General exclusions* in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard and Basic Option benefits, contact us at the customer service telephone number on the back of your Service Benefit Plan ID card or at our Web site at www.fepblue.org.

Each option offers unique features.

- **Standard Option**

When you have Standard Option, you can use both Preferred and Non-preferred providers. However, your out-of-pocket expenses are lower when you use Preferred providers and Preferred providers will submit claims to us on your behalf. Standard Option has a calendar year deductible for some services and a \$15 copayment for office visits. Standard Option also features both a Preferred retail and a Preferred mail service prescription drug program.

- **Basic Option**

Basic Option does not have a calendar year deductible. Most services are subject to copayments (\$20 for primary care providers and \$30 for specialists). Members do not need to have referrals to see specialists. You must use Preferred providers for your care to be eligible for benefits, except in certain circumstances, such as emergency care. Preferred providers will submit claims to us on your behalf. Basic Option also offers a Preferred retail pharmacy program.

Section 5(a) Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option**, the calendar year deductible is \$250 per person (\$500 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under Standard Option**, we provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- **Under Basic Option**, there is no calendar year deductible.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See below and page 11 for the exceptions to this requirement.**
- **Under Basic Option**, we provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- Please refer to Section 3, *How you receive benefits*, for a list of providers we consider to be primary care providers (under Basic Option) and other health care professionals.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.
- The amounts listed in this section are for the charges billed by a physician or other health care professional for your medical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital or other outpatient facility, etc.).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.



Benefit Description

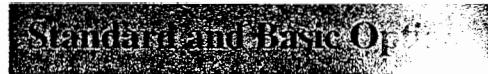
You Pay

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” when the Standard Option deductible does not apply.

There is no calendar year deductible under Basic Option.

Diagnostic and treatment services	Standard Option	Basic Option
<p>Professional services of physicians and other health care professionals:</p> <ul style="list-style-type: none"> • Outpatient consultations • Outpatient second surgical opinions • Office visits • Home visits • Initial examination of a newborn needing definitive treatment when covered under a family enrollment • Pharmacotherapy [see Section 5(f) for prescription drug coverage] • Neurological testing 	<p>Preferred: \$15 copayment for the office visit charge (No deductible)</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p>

Diagnostic and treatment services – continued on next page



Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does not apply.
There is no calendar year deductible under Basic Option.

Diagnostic and treatment services (continued)	You Pay	
	Standard Option	Basic Option
<p>Inpatient professional services:</p> <ul style="list-style-type: none"> • During a hospital stay • Services for nonsurgical procedures when ordered, provided, and billed by a physician during a covered inpatient hospital admission • Medical care by the attending physician (the physician who is primarily responsible for your care when you are hospitalized) on days we pay inpatient hospital benefits <p>Note: A consulting physician employed by the hospital is not the attending physician.</p> <ul style="list-style-type: none"> • Consultations when requested by the attending physician • Concurrent care – hospital inpatient care by a physician other than the attending physician for a condition not related to your primary diagnosis, or because the medical complexity of your condition requires this additional medical care • Physical therapy by a physician other than the attending physician • Initial examination of a newborn needing definitive treatment when covered under a family enrollment • Pharmacotherapy [see Section 5(c) for our coverage of drugs you receive while in the hospital] • Neurological testing • Second surgical opinion • Nutritional counseling when billed by a covered provider 	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>

Diagnostic and treatment services – continued on next page



Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does not apply.
There is no calendar year deductible under Basic Option.

Diagnostic and treatment services (continued)	You Pay	
	Standard Option	Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Routine services except for those Preventive care services described below and on pages 29-31 • Inpatient private duty nursing • Standby physicians • Routine radiological and staff consultations required by hospital rules and regulations • Inpatient physician care when your hospital admission or portion of an admission is not covered [see Section 5(c)] <p>Note: If we determine that a hospital admission is not covered, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.</p>	<i>All charges</i>	<i>All charges</i>
<p>Lab, X-ray, and other diagnostic tests</p> <p>Diagnostic tests provided, or ordered and billed by a physician, such as:</p> <ul style="list-style-type: none"> • Blood tests • Bone density tests – screening or diagnostic • CT scans/MRIs • EKGs and EEGs • Laboratory tests • Pathology services • Ultrasounds • Urinalysis • X-rays <p>Diagnostic services billed by an independent laboratory</p> <p>Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.</p>	<p>Preferred primary care provider or other health care professional: Nothing</p> <p>Preferred specialist: Nothing</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>

Lab, X-ray, and other diagnostic tests – continued on next page

Standard and Basic Option

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does not apply.
There is no calendar year deductible under Basic Option.

Lab, X-ray, and other diagnostic tests (continued)	You Pay	
	Standard Option	Basic Option
<p>Other diagnostic tests provided, or ordered and billed by a physician, such as:</p> <ul style="list-style-type: none"> • Fecal occult blood tests • Non-routine mammograms • Non-routine Pap tests • Prostate Specific Antigen (PSA) tests • Sigmoidoscopies • Ultrasound for aortic abdominal aneurysm <p>Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred: \$15 copayment for associated office visits (No deductible); nothing for services or tests</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.</p>	<p>Preferred primary care provider or other health care professional: Nothing</p> <p>Preferred specialist: Nothing</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>
Preventive care, adult		
<p>Home and office visits for routine (screening) physical examinations</p> <p>Under Standard Option, benefits are limited to the following services when performed as part of a routine physical examination:</p> <ul style="list-style-type: none"> • History and risk assessment • Chest X-ray • EKG • Urinalysis • General health panel • Basic or comprehensive metabolic panel test • CBC • Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides) when performed by a Preferred provider or any independent laboratory <p>Note: The benefits listed above do not apply to children up to age 22. (See benefits under <i>Preventive care, children</i>, this section.)</p> <ul style="list-style-type: none"> • Chlamydial infection test <p>Under Basic Option, benefits are provided for all of the services listed above and for other appropriate screening tests and services.</p>	<p>Preferred: \$15 copayment for the examination (No deductible); nothing for services or tests</p> <p>Note: We provide benefits for adult routine physical examinations only when you receive these services from a Preferred provider.</p> <p>Participating: You pay all charges</p> <p>Non-participating: You pay all charges</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p> <p>Note: See Section 5(c) for our payment levels for these services when billed for by a facility, such as the outpatient department of a hospital.</p>

Preventive care, adult – continued on next page



Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does not apply.
There is no calendar year deductible under Basic Option.

Preventive care, adult (continued)	You Pay	
	Standard Option	Basic Option
Cancer screening		
• Colorectal cancer screening, including:		
– Fecal occult blood test	Preferred: \$15 copayment for associated office visits (No deductible); nothing for services or tests	Preferred primary care provider or other health care professional: \$20 copayment per visit
– Colonoscopy	Note: We provide benefits in full for preventive (screening) tests and immunizations only when you receive these services from a Preferred provider on an outpatient basis. If these services are billed separately from the routine physical examination, you may be responsible for paying an additional copayment for each office visit billed.	Preferred specialist: \$30 copayment per visit
– Sigmoidoscopy		Note: You pay 30% of the Plan allowance for drugs and supplies.
– Double contrast barium enema		Participating/Non-participating: You pay all charges
• Prostate cancer screening – Prostate Specific Antigen (PSA) test		Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
• Cervical cancer screening		
• Breast cancer screening (routine mammograms)		Note: See Section 5(c) for our payment levels for these services when billed for by a facility, such as the outpatient department of a hospital.
Other screening		
• Ultrasound for aortic abdominal aneurysm		

Preventive care, adult – continued on next page



Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does not apply.
There is no calendar year deductible under Basic Option.

Preventive care, adult (continued)	You Pay	
	Standard Option	Basic Option
<p>Routine immunizations without regard to age, limited to:</p> <ul style="list-style-type: none"> • Hepatitis immunizations (Types A and B) for patients with increased risk or family history • Influenza and pneumococcal vaccines, annually • Tetanus-diphtheria (Td) booster – once every 10 years 	<p>Preferred: \$15 copayment for associated office visits (No deductible); nothing for immunizations</p> <p>Participating: 25% of the Plan allowance</p> <p>Nor-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment for associated office visits; nothing for immunizations</p> <p>Preferred specialist: \$30 copayment for associated office visits; nothing for immunizations</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered: Office visit charges associated with preventive services and routine immunizations performed by Participating and Non-participating providers</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Preventive care, children		
<p>We provide benefits for the following services:</p> <ul style="list-style-type: none"> • All healthy newborn visits including routine screening (inpatient or outpatient) • The following routine services as recommended by the American Academy of Pediatrics for children up to the age of 22, including children living, traveling, or adopted from outside the United States: <ul style="list-style-type: none"> – Routine physical examinations – Routine hearing tests – Laboratory tests – Immunizations – Meningococcal vaccine – Related office visits 	<p>Preferred: Nothing (No deductible)</p> <p>Participating: Nothing (No deductible)</p> <p>Non-participating: Nothing (No deductible) up to the Plan allowance. You are responsible only for any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred primary care provider or other health care professional: Nothing</p> <p>Preferred specialist: Nothing</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>

Standard and Basic Option

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does not apply.
There is no calendar year deductible under Basic Option.

Maternity care	You Pay	
	Standard Option	Basic Option
<p>Complete maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage when provided, or ordered and billed by a physician or nurse midwife, such as:</p> <ul style="list-style-type: none"> • Prenatal care (including laboratory and diagnostic tests) • Tocolytic therapy and related services (when provided and billed by a home infusion therapy company or a home health care agency) <p>Note: Benefits are not provided for oral tocolytic agents. Benefits for home nursing visits related to covered tocolytic therapy are subject to the visit limitations described on page 42.</p> <ul style="list-style-type: none"> • Delivery • Postpartum care • Assistant surgeons/surgical assistance by a physician if required because of the complexity of the delivery • Anesthesia (including acupuncture) when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician other than the operating physician (surgeon) or the assistant 	<p>Preferred: Nothing (No deductible)</p> <p>Note: For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use Preferred providers.</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Note: For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered inpatient services is limited to \$100 per admission. For outpatient facility services related to maternity, see pages 62-64.</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: For services billed by Participating and Non-participating laboratories and radiologists, you are responsible only for any difference between our allowance and the billed amount.</p>

Maternity care – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does not apply.
There is no calendar year deductible under Basic Option.

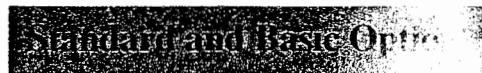
Maternity care (continued)	You Pay	
	Standard Option	Basic Option
<p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you, your representative, your doctor, or your hospital must precertify the extended stay. See Section 3 for information on requesting additional days. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay, or if the child is covered under the father's Self and Family enrollment. <p>Note: When a newborn requires definitive treatment including incubation charges by reason of prematurity or evaluation for medical or surgical reasons during or after the mother's confinement, the newborn is considered a patient in his or her own right.</p> <p>Note: Expenses of the newborn are eligible for benefits only if the child is covered by a Self and Family enrollment. For services such as circumcision, regular medical or surgical benefits apply rather than maternity benefits.</p> <p>Note: See page 46 for our payment levels for circumcision.</p>		
<p><i>Not covered: Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest</i></p>	All charges	All charges



Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does not apply.
 There is no calendar year deductible under Basic Option.

Family planning	You Pay	
	Standard Option	Basic Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Depo-Provera • Diaphragms and contraceptive rings • Intrauterine devices (IUDs) • Implantable contraceptives • Oral and transdermal contraceptives • Voluntary sterilization [see Surgical procedures in Section 5(b)] <p>Note: See Section 5(f) for prescription drug coverage.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay \$100 for related surgical procedures. See Section 5(b) for our coverage for related surgical procedures.</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Contraceptive devices not described above</i> 	<i>All charges</i>	<i>All charges</i>
<p>Infertility services</p> <p>Diagnosis and treatment of infertility, except as shown in <i>Not Covered</i></p> <p>Note: See Section 5(f) for prescription drug coverage.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>

Infertility services – continued on next page



Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does not apply.
There is no calendar year deductible under Basic Option.

Infertility services (continued)	You Pay	
	Standard Option	Basic Option
<i>Not covered:</i>		
<ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> – <i>artificial insemination (AI)</i> – <i>in vitro fertilization (IVF)</i> – <i>embryo transfer and Gamete Intrafallopian Transfer (GIFT)</i> – <i>intravaginal insemination (IVI)</i> – <i>intracervical insemination (ICI)</i> – <i>intrauterine insemination (IUI)</i> • Services and supplies related to ART procedures, such as sperm banking 	<i>All charges</i>	<i>All charges</i>
Allergy care		
<ul style="list-style-type: none"> • Testing and treatment, including materials (such as allergy serum) • Allergy injections 	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: \$20 copayment per visit; nothing for injections Preferred specialist: \$30 copayment per visit; nothing for injections Participating/Non-participating: You pay all charges <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>	<i>All charges</i>



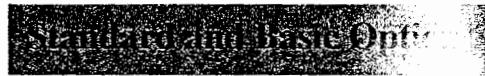
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does not apply.
There is no calendar year deductible under Basic Option.

Treatment therapies	You Pay	
	Standard Option	Basic Option
<p>Outpatient treatment therapies:</p> <ul style="list-style-type: none"> Chemotherapy and radiation therapy <p>Note: We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under Organ/tissue transplants in Section 5(b). See also, <i>Other services under How to get approval for . . .</i> in Section 3 (page 14).</p> <ul style="list-style-type: none"> Renal dialysis – Hemodialysis and peritoneal dialysis Intravenous (IV)/infusion therapy – Home IV or infusion therapy <p>Note: Home nursing visits associated with Home IV/infusion therapy are covered as shown under Home health services on page 42.</p> <ul style="list-style-type: none"> Outpatient cardiac rehabilitation <p>Note: See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p>
<p>Inpatient treatment therapies:</p> <ul style="list-style-type: none"> Chemotherapy and radiation therapy <p>Note: We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under Organ/tissue transplants in Section 5(b). See also, <i>Other services under How to get approval for . . .</i> in Section 3 (page 14).</p> <ul style="list-style-type: none"> Renal dialysis – Hemodialysis and peritoneal dialysis Pharmacotherapy {see Section 5(c) for our coverage of drugs administered in connection with these treatment therapies} 	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>



Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does not apply.
There is no calendar year deductible under Basic Option.

Physical therapy, occupational therapy, speech therapy, and cognitive therapy	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> Physical therapy, occupational therapy, and speech therapy when performed by a licensed therapist or physician Cognitive rehabilitation therapy when performed by a licensed therapist or physician <p>Note: When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for professional care, according to the contracting status of the therapist.</p>	<p>Preferred: \$15 copayment per visit (No deductible)</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.</p> <p>Note: Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Note: Benefits are limited to 50 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: See Section 5(c) for our payment levels for rehabilitative therapies billed for by the outpatient department of a hospital.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay Maintenance or palliative rehabilitative therapy Exercise programs Hippotherapy (exercise on horseback) 	<i>All charges</i>	<i>All charges</i>



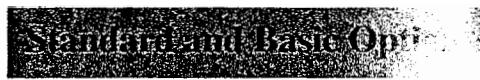
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does not apply.
There is no calendar year deductible under Basic Option.

Hearing services (testing, treatment, and supplies)	You Pay	
	Standard Option	Basic Option
Hearing tests related to illness or injury	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: \$20 copayment per visit Preferred specialist: \$30 copayment per visit Note: You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>
<ul style="list-style-type: none"> <i>Routine hearing tests (except as indicated under Preventive care, children)</i> <i>Hearing aids (including implanted bone conduction hearing aids)</i> <i>Testing and examinations for the prescribing or fitting of hearing aids</i> 		
Vision services (testing, treatment, and supplies)		
Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed: <ul style="list-style-type: none"> To correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery; In lieu of surgery when the condition can be corrected by surgery, but surgery is precluded because of age or medical condition 	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
<ul style="list-style-type: none"> <i>Eye examinations related to a specific medical condition</i> <i>Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 12</i> <p>Note: See Section 5(b), <i>Surgical procedures</i>, for coverage for surgical treatment of amblyopia and strabismus.</p>	Preferred: \$15 copayment (No deductible) Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: \$20 copayment per visit Preferred specialist: \$30 copayment per visit Note: You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges

Vision services (testing, treatment, and supplies) – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does not apply.
There is no calendar year deductible under Basic Option.

Vision services (testing, treatment, and supplies) (continued)	You Pay	
	Standard Option	Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as described on page 38</i> • <i>Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described on page 38</i> • <i>LASIK, radial keratotomy, and other refractive services</i> 	<i>All charges</i>	<i>All charges</i>
Foot care		
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p> <p>Note: See Section 5(b) for our coverage for surgical procedures.</p>	Preferred: \$15 copayment for the office visit (No deductible); 10% of the Plan allowance for all other services (deductible applies) Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: \$20 copayment per visit Preferred specialist: \$30 copayment per visit <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> Participating/Non-participating: You pay all charges
<i>Not covered: Routine foot care, such as cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i>	<i>All charges</i>	<i>All charges</i>



Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when the Standard Option deductible does not apply.
There is no calendar year deductible under Basic Option.

Orthopedic and prosthetic devices	You Pay	
	Standard Option	Basic Option
<p>Orthopedic braces and prosthetic appliances such as:</p> <ul style="list-style-type: none"> • Artificial limbs and eyes • Functional foot orthotics when prescribed by a physician • Rigid devices attached to the foot or a brace, or placed in a shoe • Replacement, repair, and adjustment of covered devices • Following a mastectomy, breast prostheses and surgical bras, including necessary replacements <p>Note: A prosthetic appliance is a device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body.</p> <p>We provide hospital benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b).</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Shoes and over-the-counter orthotics</i> • <i>Arch supports</i> • <i>Heel pads and heel cups</i> • <i>Penile implants (except for surgically implanted penile prosthesis to treat erectile dysfunction resulting from prostatectomy to treat prostate cancer)</i> • <i>Wigs (including cranial prostheses)</i> • <i>Implanted bone conduction hearing aids</i> 	<i>All charges</i>	<i>All charges</i>